Acceptable POC 3/1/11

PRINTED: 01/05/2011
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2725AGC	A. BUILDING _____ B. WING _____	01/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE LOVE FACILITY	1211 NORTH H STREET LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 1/4/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A. The facility is licensed for four Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category I residents. The census at the time of the survey was three. No resident files were reviewed and three employee files were reviewed. The following deficiencies were identified:	Y 000		
Y 106 SS=D	449.200(2)(a) Personnel File - 1st aid & CPR NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation.	Y 106	OK 3/1/11 KL	

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This Regulation is not met as evidenced by:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Emma Love TITLE Director (X6) DATE 2/22/2011

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Y 106	Continued From page 1 Based on record review on 1/4/10,the facility failed to ensure that 1 of 3 caregivers were trained in first aid and cardiopulmonary resuscitation (Employee #3-CPR card had expired on 9/20/10). Severity: 2 Scope: 1	Y 106	Y(106) A. Employee has completed her first aid and her cpr class on Janunary 13,2011. B. All employees files will be monitored every six months and a check list will be placed in each file. C .Administrator will monitor to make sure that we are in compliance. Please see attachment. Y(106)	
Y 253 SS=F	449.217(4) Adequate Supplies of Food NAC 449.217 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. This Regulation is not met as evidenced by: Based on observation and interview on 1/4/10, the facility failed to provide at least a 2-day supply of fresh food in the facility for 3 of 3 residents. This was a repeat deficiency from the 8/24/10 annual State Licensure survey. Severity: 2 Scope: 3	Y 253	OK 3/1/11 KL Y(252) A.Food supplies was restocked on 1/4/2011. B. Administrator will monitor food supplies And restock supplies as needen. Please see attatchment Y(253)	

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